2006 Plan Comparison Chart

	Health Maintenance Organization (HMO) Preferred Plus of Kansas Premier Blue Coventry HMO	Preferred Provider Organization (PPO) Coventry PPO Kansas Choice	
BASIC PROVISIONS			
Deductible (not included in coinsurance maximums)	n/a	Network	Non Network
Single		$0	$500
Family		$0	$1,500
Coinsurance	10%	65/35%	50/50%
Coinsurance Maximum	$1,000 single/$2,000 family	$2,200/$4,400	$3,650/$7,300
Copayments - (copays are not included in the coinsurance maximum.)			
Physician Office Visit	$20 PCP / $30 Specialist	Coinsurance	Deductible & Coinsurance
Emergency Room	$75	$100	$200
Urgent Care	$30	Coinsurance	Deductible & Coinsurance
Hospital Admission	$200	$300	$600
Outpatient Mental Health (Not Biologically Based)	$25	$25	$25
Outpatient Surgery*	$100	Coinsurance	Deductible & Coinsurance
Major Diagnostic Tests*	$100 then Coinsurance	Coinsurance	Deductible & Coinsurance
Lifetime Benefit Maximum	$3,000,000 per person	$3,000,000 per person	
Primary Care Physician (PCP)	PCP manages and/or directs all care.	PCP not required.	
Provider Choice	Local Network. Referrals required by Primary Care Physician for care by any other provider.	Freedom to use provider of choice, benefits based on plan description, coverage level based on provider network status.	
Non Network Care	Covered only for initial treatment of medical emergency or if pre-approved by health plan.	Coninsurance	Subject to Deductible, Coinsurance, & Copay
Out of Area Care	Must be Referred by PCP and Pre-Approved by Health Plan.	Coninsurance	Subject to Deductible Coinsurance, & Copay
Amounts Above Plan Allowance	Provider to write off	Provider to write off	Member responsibility
COVERED SERVICES			
Inpatient Services	Copay, then Coinsurance	Subject to Copay and Coinsurance	Subject to Copay and e Coinsurance
Physician Hospital Visits	Subject to Coinsurance	Subject to Coinsurance	Subject to Deductible & Coinsurance
Physician Office Visits			
PCP	Subject to $20 copay	Subject to Coinsurance	Subject to Deductible and Coinsurance
Specialist	Subject to $30 copay	Subject to Coinsurance	Subject to Deductible and Coinsurance
Urgent Care Center	Subject to $30 copay	Subject to Coinsurance	Subject to Deductible and Coinsurance

* These copayments not included in coinsurance maximums. These services may require coinsurance.

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Covered Services continued		Network	Non Network
Outpatient Surgery	Subject to $100 copayment per surgery, then subject to coinsurance	Subject to Coinsurance	Subject to Deductible and Coinsurance
Emergency Room Visits	Subject to $75 copay (waived if admitted) then subject to coinsurance	Subject to Copay and Coinsurance	Subject to Copay, Deductible and Coinsurance
Other Outpatient Services	Subject to Coinsurance	Subject to Coinsurance	Subject to Deductible and Coinsurance
Ambulance Services	Subject to Coinsurance	Subject to Coinsurance	Subject to Deductible and Coinsurance
Major Diagnostic Tests (includes but not limited to: PET Scans CT Scans, Nuclear Cardiology Studies, Magnetic Resonance Angiography and Computerized Topography Angiography	Subject to $100 copayment per test per day then subject to Coinsurance.	Subject to Coinsurance	Subject to Deductible and Coinsurance
Home Health Care	Services must be pre-approved by Health Plan. Subject to Coinsurance. Limited to $5,000/ benefit period.	Services must be pre-approved by Health Plan. . Limited to $5,000 per benefit period.	
		Subject to Coinsurance	Subject to Deductible & Coinsurance
Hospice	Services must be pre-approved by Health Plan. Limited to $7,500/lifetime. Subject to Coinsurance.	Services must be pre-approved by Health Plan. Limited to $7,500/lifetime. Subject to Coinsurance.	Subject to Deductible and Coinsurance
X-Ray and Laboratory	Subject to Coinsurance.	Subject to Coinsurance. (PET Scans require Pre-Approval by Health Plan)	Subject to Ded & Coins (PET Scans require Pre-Approval by Health Plan)
Physical Rehabilitation Services (including chiropractic care)	Services limited to those medically necessary and appropriate and medical records must show continued improvement in condition.	Services limited to those medically necessary and appropriate and medical records must show continued improvement in condition.	
Facility - Inpatient	Subject to Copay & Coinsurance - subject to continued improvement	Subject to Copay & Coinsurance-subject to continued improvement (Pre-approved by Health Plan)	Subject to Copay. Deductible & Coinsurance - subject to continued improvement (Pre-approved by Health Plan)
Facility - Outpatient	Subject to Coinsurance - subject to continued improvement	Subject to Coinsurance -subject to continued improvement	Subject to Deductible & Coinsurance - subject to continued improvement
Office Based	Subject to Copay & Coinsurance - limited to 30 visits per year	Subject to Coinsurance limited to 30 visits per year	Subject to Deductible & Coinsurance, limited to 30 visits per year

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Covered Services continued		Network	Non Network
Durable Medical Equipment	Services must be pre-approved by Health Plan and subject to 10% Coinsurance, limited to $5,000 per person per year of covered services	Subject to Coinsurance $4,500 per person per year (pre-approved by Health Plan)	Subject to Deductible & Coinsurance, limited to $4,500 per person per year (pre-approved by Health Plan)
Allergy Testing	As approved by Primary Care Physician & precertified by Health Plan, Subject to Office Visit Copayment then Coinsurance	Subject to Coinsurance (pre-approved by Health Plan)	Subject to Deductible & Coinsurance (pre-approved by Health Plan)
Antigen Administration (desensitazation/treatment) Allergy Shots	As approved by Primary Care Physician by Health Plan, subject to office visit copayment and Coinsurance	Subject to Coinsurance (pre-approved by Health Plan)	Subject to Deductible & Coinsurance (pre-approved by Health Plan)
Infertility Treatment (limited to testing & 3 attempts at artificial insemination per year)	As approved by Primary Care Physician. & Precertified by Health Plan. Subject to office visit copayment then Coinsurance	Subject to Coinsurance (pre-approved by Health Plan)	Subject to Deductible & Coinsurance (pre-approved by Health Plan)
Childhood Immunizations to Age 5	Covered in full	Covered in full	Covered in full
MENTAL HEALTH			
Inpatient Nervous & Mental/Drug & Alcohol	Subject to inpatient Copayment, then Coinsurance 60-day Limit/yr	Subject to inpatient Copayment, then Coinsurance 60-day Limit/yr	Subject to Copay and Coinsurance 30-day Limit/yr
Outpatient Nervous & Mental/Drug & Alcohol	First 3 visits @ 100%, next 22 visits - $25 copay; additional visits @ 50%	Both in and out-of-network visits will be counted towards first 25 visits First 3 visits @ 100%, next 22 visits @ $25 copay, additional visits @ 50%	First 3 visits @ 100%, next 22 visits @ 50%, 25 visit limit.
Biologically Based Mental Health Conditions	Benefits same as medical conditions for certain specified mental health conditions	Benefits same as medical conditions for certain specified mental health conditions	
PREVENTIVE CARE			
Preventive Care Services	Limited to one per calendar year	Preventive Care Service Allowance = 1st $450/person covered in full, then subject to Coinsurance	Not Covered
Age Appropriate Routine Physical Exam	Must be provided by PCP Copay waived for one visit per person per year	Preventive Care Service Allowance, then subject to Coinsurance	Not Covered

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Preventive Care Services continued		Network	Non Network
Well-Woman Care (office visit and PAP smear test, & STD testing)	Subject to Office Visit Copayment - No referral required. - Must use Network Provider	Preventive Care Service Allowance, then subject to Coinsurance	Not Covered
Well-Man Care (office visit and PSA blood test)	Subject to Office Visit Copayment - No referral required. - Must use Network Provider	Preventive Care Service Allowance, then subject to Coinsurance	Not Covered
Mammogram (recommended frequency age 35-39 = 1 baseline; age 40-49 = every 2 years; age 50+ = annually)	Covered in Full - no referral required - Must use network provider	Preventive Care Service Allowance, then subject to Coinsurance	Not Covered
Dietitian Consultation (for medical management of a documented disease)	As approved by Primary Care Physician and subject to Office Visit Copayment	Preventive Care Allowance then subject to Coinsurance	Not Covered
Routine Hearing Exam	As approved by Primary Care Physician. Subject to office visit Copayment.	Preventive Care Allowance then subject to Coinsurance	Not Covered
Routine Vision Exam (Refraction Exam for Glasses - Lenses and frames NOT covered)	Limited to one per year. Copay waived for one routine visit per year. No referral required	Preventive Care Allowance then subject to Coinsurance	Not Covered
Age Appropriate Bone Density Screening	As approved by Primary Care Physician and Precertified by Health Plan. Covered in full	Preventive Care Allowance then subject to Coinsurance	Not Covered
PRESCRIPTION DRUG SERVICES	Covered by separate contract with Caremark	Covered by separate contract with Caremark	
DENTAL SERVICES	Covered by separate contract with Delta Dental	Covered by separate contract with Delta Dental	
NON-COVERED SERVICES			
TMJ/Orthognathic Surgery	Not Covered under Medical - see Dental, limited	Not Covered under Medical - see Dental, limited	
Orthotics	Not Covered	Not Covered	
Gastric Surgery and Other **Weight Loss Treatments**	Not Covered	Not Covered	